DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing HFS 107.06(3)(c), Wis. Admin. Code
HCF 1160 (Rev. 01/03)

WISCONSIN MEDICAID
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: The Acknowledgement of Receipt of Hysterectomy Information form is to be completed by a physician before performing the surgery and attached to the CMS 1500 claim form. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of this form or similar form with the same information. This form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form.

Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The name in this element must match the name on the claim.

Address — Recipient
Enter the recipient's address. Use the EVS to obtain the address.

Recipient's Medicaid ID No.
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.

Name — Physician
Enter the performing provider's name.

Physician's Medicaid Provider No.
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

Name — Recipient
Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.

Signatures — Recipient, Representative, and Interpreter
Recipient — The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)

Representative — The representative must sign and date this element if a representative was required for the recipient.

Interpreter — An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.

Date Signed
Enter the date the recipient signs the Acknowledgement of Receipt of Hysterectomy Information form in this element. This date must be ***on or before*** the date of service on the claim.

WISCONSIN MEDICAID

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Name — Recipient		Address — Recipient
Recipient's Medicaid ID No.	Name — Physician	Physician's Medicaid Provider No.

It has been explained to _____ that the hysterectomy to be
(Name — Recipient)

performed on her (me) will render her (me) permanently incapable of reproducing.

SIGNATURES — Recipient, Representative, and Interpreter

Recipient

Representative

Interpreter

Date Signed

Reset Form